SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

Filing at a Glance

Companies: Chubb Indemnity Insurance Company, Federal Insurance Company, Great Northern Insurance Company, Pacific Indemnity Company, Vigilant Insurance Company

Product Name: Workers Compensation	SERFF Tr Num: CHUB-125640433	State: Arkansas
TOI: 16.0 Workers Compensation	SERFF Status: Closed	State Tr Num: #? $50
Sub-TOI: 16.0000 WC Sub-TOI Combinations	Co Tr Num: 08-C-4-F	State Status: Fees verified
Filing Type: Form	Co Status:	Reviewer(s): Betty Montesi, Carol Stiffler, Brittany Yielding
	Author: Berenice Camillo	Disposition Date: 05/15/2008
	Date Submitted: 05/14/2008	Disposition Status: Approved
Effective Date Requested (New):		Effective Date (New): 05/15/2008
Effective Date Requested (Renewal):		Effective Date (Renewal):

State Filing Description:

Brittany, they have sent 5 checks for $50 each which is an overpayment. We need to return 4 of the checks to them. If you catch them before they are sent to accounting, give them to me and I'll take care of them.

General Information

Project Name: Great Northern Redomestication	Status of Filing in Domicile: Pending
Project Number: 08-C-4-RR	Domicile Status Comments:
Reference Organization:	Reference Number:
Reference Title:	Advisory Org. Circular:
Filing Status Changed: 05/15/2008	
State Status Changed: 05/15/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Informational Filing

Dear Sir or Madam:

Enclosed for your information are the following:

SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

Information Page and Extension of Information Pages, Form WC 00 00 01A (Rev. 5-88)

Effective November 30, 2007, Great Northern Insurance Company was re-domesticated from Minnesota to Indiana. We have enclosed a copy of the letter approving the re-domestication to Indiana as submitted to us by the Commissioner of Indiana.

We are enclosing the Information Page and Extension of Information Pages for all writing companies removing the incorporated state and the entry under 3C, Other States Insurance. This filing is classified as informational as the fields in question are variable fields that are now being submitted unfilled so as to eliminate this as an issue going forward should another company be re-domesticated or another state cease being monopolistic (for field 3C). This is an informational only filing as the forms are identical in content/text but differ in appearance; the information does not affect an insureds policy nor does it impact the quality of coverage.

Your acknowledgment will be appreciated.

Company and Contact

Filing Contact Information

Jane Gutman, Unit Manager	jgutman@chubb.com	
202 Hall's Mill Road	(908) 572-4422 [Phone]	
Whitehouse Station, NJ 08889-1650	(908) 572-4820[FAX]	

Filing Company Information

Chubb Indemnity Insurance Company	CoCode: 12777	State of Domicile: New York
202 Hall's Mill Road	Group Code: 38	Company Type:
P.O. Box 1650		
Whitehouse Station, NJ 08889-1650	Group Name:	State ID Number:
(908) 572-4726 ext. [Phone]	FEIN Number: 22-3291862	

Federal Insurance Company	CoCode: 20281	State of Domicile: Indiana
202 Hall's Mill Road	Group Code: 38	Company Type:
P.O. Box 1650		
Whitehouse Station, NJ 08889-1650	Group Name:	State ID Number:

SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

(908) 572-4726 ext. [Phone]

FEIN Number: 13-1963496

Great Northern Insurance Company
202 Hall's Mill Road
P.O. Box 1650
Whitehouse Station, NJ 08889-1650
(908) 572-4726 ext. [Phone]

CoCode: 20303
Group Code: 38
Group Name:
FEIN Number: 41-0729473

State of Domicile: Indiana
Company Type:
State ID Number:

Pacific Indemnity Company
202 Hall's Mill Road
P.O. Box 1650
Whitehouse Station, NJ 08889-1650
(908) 572-4726 ext. [Phone]

CoCode: 20346
Group Code: 38
Group Name:
FEIN Number: 95-1078160

State of Domicile: Wisconsin
Company Type:
State ID Number:

Vigilant Insurance Company
202 Hall's Mill Road
P.O. Box 1650
Whitehouse Station, NJ 08889-1650
(908) 572-4726 ext. [Phone]

CoCode: 20397
Group Code: 38
Group Name:
FEIN Number: 13-1963495

State of Domicile: New York
Company Type:
State ID Number:

SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$250.00
Retaliatory?	No
Fee Explanation:	Check #'s: 370661, 370662, 370663, 370664, 370665
	Amount: 50 each for a total of $250
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Chubb Indemnity Insurance Company	$0.00	05/14/2008	
Federal Insurance Company	$0.00	05/14/2008	
Great Northern Insurance Company	$0.00	05/14/2008	
Pacific Indemnity Company	$0.00	05/14/2008	
Vigilant Insurance Company	$0.00	05/14/2008	

SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Carol Stiffler	05/15/2008	05/15/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Carol Stiffler	05/15/2008	05/15/2008	Berenice Camillo	05/15/2008	05/15/2008

SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

Disposition

Disposition Date: 05/15/2008
Effective Date (New): 05/15/2008
Effective Date (Renewal):
Status: Approved
Comment: I will try to intercept the overpayment checks before they are sent to accounting. If I do not, we will do a refund request.

Rate data does NOT apply to filing.

Overall Rate Information for Multiple Company Filings	
Overall Percentage Rate Indicated For This Filing	0.000%
Overall Percentage Rate Impact For This Filing	0.000%
Effect of Rate Filing-Written Premium Change For This Program	$0
Effect of Rate Filing - Number of Policyholders Affected	0

SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	IN Re-domestication Letter	Approved	Yes
Form	Information Page and Extension of Information Pages	Approved	Yes

SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/15/2008
Submitted Date	05/15/2008
Respond By Date	

Dear Jane Gutman,

The filing fee we received is $250 but the required fee is only $50. A form filing is $50 no matter how many forms or companies it is for. You will need to request a refund. This can be done by a response to this objection letter. Please refer to the SERFF filing # and the EFT transaction #. At this time it is almost impossible for us to refund an EFT by issuing an EFT. We will need to do it by check.

Please feel free to contact me if you have questions.
Sincerely,
Carol Stiffler

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/15/2008
Submitted Date	05/15/2008

Dear Carol Stiffler,

Comments:

Response 1

Comments: Thank you for your letter of 5-15-08 explaining the filing fee was should have been $50.

The payment was not made via EFT but mailed via 5 checks ($50 each) for a total of $250. Please accept this response as a request that 4 of the $50 checks submitted be returned as a refund.

If this is not possible, please send a refund check in the amount of $200.

Thank you for your help.

Changed Items:

SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Berenice Camillo

SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Information Page and Extension of Information Pages	WC 00 00 01A	(Rev. 5-88)	Declaration Replaced s/Schedule	Replaced Form #: WC 00 00 01A (Rev. 5-88) Previous Filing #:	0.00	F.pdf GN.pdf CI.pdf PI.pdf V.pdf

Chubb Group of Insurance Companies

15 Mountain View Road, Warren, NJ 07060

INFORMATION PAGE
WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

Item 1. Name & Mailing Address of the Insured

Issued by FEDERAL INSURANCE COMPANY
a stock insurance company
incorporated in

N.C.C.I. Carrier Code

FEIN
Insured is:

Policy Number

Name & Address of the Producer

Previous Policy Number

Producer Number

OTHER WORK PLACES NOT SHOWN ABOVE - SEE ATTACHED EXTENSION OF INFORMATION PAGE

Item 2. POLICY PERIOD
12:01 A.M. standard time at the insured's mailing address FROM TO

Item 3. A. WORKERS COMPENSATION INSURANCE: Part One of the policy applies to the Workers Compensation Law of the states listed here: Refer To Extension of Information Page "Covered States"

B. EMPLOYERS LIABILITY INSURANCE: Part Two of the policy applies to work in each statelisted in Item 3A. The limits of our liability under Part Two are:

Bodily Injury by Accident	$	each accident
Bodily Injury by Disease	$	policy limit
Bodily Injury by Disease	$	each employee

C. OTHER STATES INSURANCE: Part Three of the policy applies to the states, if any, listed here: All States, Except states designated in Item 3.A and

D. Endorsements (Form No.) Refer To Extension of Information Page "List of Endorsements & Schedules"

Item 4. The Premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Refer to Extension of Information Page

Minimum Premium:		Total Estimated Premium	$
Minimum Premium State:		Total State Surcharges	$
Expense Constant:		Total Estimated Charge	$
Premium Adjustment Period:		Deposit Amount	$

Authorized Representative and Date Signed

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of Policy Number

Policy Period **to**

FEIN

Effective Date

Name & Address of the Producer

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGE

ITEM 1.

NAMED INSURED

It is agreed that Item 1 of the Workers Compensation and Employers Liability Policy Information Page includes the following Named Insureds:

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period **to**

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGES
ITEM 3.A.
COVERED STATES

It is agreed that Item 3.A. of the Workers Compensation and Employers Liability Policy Information Page includes the following states:

State	Risk I.D.	State I.D. No.

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period **to**

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGES

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES

It is agreed that Item 3.D. of the Workers Compensation and Employers Liability Policy Information Page includes the following endorsements and schedules:

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period to

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4

SCHEDULE NUMBER:

Classifications of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Chubb Group of Insurance Companies

15 Mountain View Road, Warren, NJ 07060

INFORMATION PAGE
WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

Item 1. Name & Mailing Address of the Insured

Issued by GREAT NORTHERN INSURANCE COMPANY
a stock insurance company
incorporated in

N.C.C.I. Carrier Code

FEIN
Insured is:

Policy Number

Name & Address of the Producer

Previous Policy Number

Producer Number

OTHER WORK PLACES NOT SHOWN ABOVE - SEE ATTACHED EXTENSION OF INFORMATION PAGE

Item 2. POLICY PERIOD
12:01 A.M. standard time at the insured's mailing address FROM TO

Item 3. A. WORKERS COMPENSATION INSURANCE: Part One of the policy applies to the Workers Compensation Law of the states listed here: Refer To Extension of Information Page "Covered States"

B. EMPLOYERS LIABILITY INSURANCE: Part Two of the policy applies to work in each statelisted in Item 3A. The limits of our liability under Part Two are:

Bodily Injury by Accident	$	each accident
Bodily Injury by Disease	$	policy limit
Bodily Injury by Disease	$	each employee

C. OTHER STATES INSURANCE: Part Three of the policy applies to the states, if any, listed here: All States, Except states designated in Item 3.A and

D. Endorsements (Form No.) Refer To Extension of Information Page "List of Endorsements & Schedules"

Item 4. The Premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Refer to Extension of Information Page

Minimum Premium:		Total Estimated Premium	$
Minimum Premium State:		Total State Surcharges	$
Expense Constant:		Total Estimated Charge	$
Premium Adjustment Period:		Deposit Amount	$

Authorized Representative and Date Signed

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of Policy Number

Policy Period **to**

FEIN

Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGE

ITEM 1.

NAMED INSURED

It is agreed that Item 1 of the Workers Compensation and Employers Liability Policy Information Page includes the following Named Insureds:

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period **to**

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGES
ITEM 3.A.
COVERED STATES

It is agreed that Item 3.A. of the Workers Compensation and Employers Liability Policy Information Page includes the following states:

State	Risk I.D.	State I.D. No.

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period **to**

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGES

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES

It is agreed that Item 3.D. of the Workers Compensation and Employers Liability Policy Information Page includes the following endorsements and schedules:

All Other Terms and Conditions Remain Unchanged

_____
Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period to

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4

SCHEDULE NUMBER:

Classifications of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Chubb Group of Insurance Companies

15 Mountain View Road, Warren, NJ 07060

INFORMATION PAGE
WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

Item 1. Name & Mailing Address of the Insured

Issued by CHUBB INDEMNITY INSURANCE COMPANY
a stock insurance company
incorporated in

N.C.C.I. Carrier Code

FEIN
Insured is:

Policy Number

Name & Address of the Producer

Previous Policy Number

Producer Number

OTHER WORK PLACES NOT SHOWN ABOVE - SEE ATTACHED EXTENSION OF INFORMATION PAGE

Item 2. POLICY PERIOD
12:01 A.M. standard time at the insured's mailing address FROM TO

Item 3. A. WORKERS COMPENSATION INSURANCE: Part One of the policy applies to the Workers Compensation Law of the states listed here: Refer To Extension of Information Page "Covered States"

B. EMPLOYERS LIABILITY INSURANCE: Part Two of the policy applies to work in each statelisted in Item 3A. The limits of our liability under Part Two are:

Bodily Injury by Accident	$	each accident
Bodily Injury by Disease	$	policy limit
Bodily Injury by Disease	$	each employee

C. OTHER STATES INSURANCE: Part Three of the policy applies to the states, if any, listed here: All States, Except states designated in Item 3.A and

D. Endorsements (Form No.) Refer To Extension of Information Page "List of Endorsements & Schedules"

Item 4. The Premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Refer to Extension of Information Page

Minimum Premium:		Total Estimated Premium	$
Minimum Premium State:		Total State Surcharges	$
Expense Constant:		Total Estimated Charge	$
Premium Adjustment Period:		Deposit Amount	$

Authorized Representative and Date Signed

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of Policy Number

Policy Period **to**

FEIN

Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGE

ITEM 1.

NAMED INSURED

It is agreed that Item 1 of the Workers Compensation and Employers Liability Policy Information Page includes the following Named Insureds:

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period **to**

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGES
ITEM 3.A.
COVERED STATES

It is agreed that Item 3.A. of the Workers Compensation and Employers Liability Policy Information Page includes the following states:

State	Risk I.D.	State I.D. No.

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period **to**

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGES

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES

It is agreed that Item 3.D. of the Workers Compensation and Employers Liability Policy Information Page includes the following endorsements and schedules:

All Other Terms and Conditions Remain Unchanged

_____
Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period to

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4

SCHEDULE NUMBER:

Classifications of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Chubb Group of Insurance Companies

15 Mountain View Road, Warren, NJ 07060

INFORMATION PAGE
WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

Item 1. Name & Mailing Address of the Insured

Issued by PACIFIC INDEMNITY COMPANY
a stock insurance company
incorporated in

N.C.C.I. Carrier Code

FEIN
Insured is:

Policy Number

Name & Address of the Producer

Previous Policy Number

Producer Number

OTHER WORK PLACES NOT SHOWN ABOVE - SEE ATTACHED EXTENSION OF INFORMATION PAGE

Item 2. POLICY PERIOD
12:01 A.M. standard time at the insured's mailing address FROM TO

Item 3. A. WORKERS COMPENSATION INSURANCE: Part One of the policy applies to the Workers Compensation Law of the states listed here: Refer To Extension of Information Page "Covered States"

B. EMPLOYERS LIABILITY INSURANCE: Part Two of the policy applies to work in each statelisted in Item 3A. The limits of our liability under Part Two are:

Bodily Injury by Accident	$	each accident
Bodily Injury by Disease	$	policy limit
Bodily Injury by Disease	$	each employee

C. OTHER STATES INSURANCE: Part Three of the policy applies to the states, if any, listed here: All States, Except states designated in Item 3.A and

D. Endorsements (Form No.) Refer To Extension of Information Page "List of Endorsements & Schedules"

Item 4. The Premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Refer to Extension of Information Page

Minimum Premium:		Total Estimated Premium	$
Minimum Premium State:		Total State Surcharges	$
Expense Constant:		Total Estimated Charge	$
Premium Adjustment Period:		Deposit Amount	$

Authorized Representative and Date Signed

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of Policy Number

Policy Period **to**

FEIN

Effective Date

Name & Address of the Producer

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGE

ITEM 1.

NAMED INSURED

It is agreed that Item 1 of the Workers Compensation and Employers Liability Policy Information Page includes the following Named Insureds:

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period **to**

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGES
ITEM 3.A.
COVERED STATES

It is agreed that Item 3.A. of the Workers Compensation and Employers Liability Policy Information Page includes the following states:

State	Risk I.D.	State I.D. No.

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period **to**

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGES

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES

It is agreed that Item 3.D. of the Workers Compensation and Employers Liability Policy Information Page includes the following endorsements and schedules:

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period to

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4

SCHEDULE NUMBER:

Classifications of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Chubb Group of Insurance Companies

15 Mountain View Road, Warren, NJ 07060

INFORMATION PAGE
WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

Item 1. Name & Mailing Address of the Insured

Issued by VIGILANT INSURANCE COMPANY
a stock insurance company
incorporated in

N.C.C.I. Carrier Code

FEIN
Insured is:

Policy Number

Name & Address of the Producer

Previous Policy Number

Producer Number

OTHER WORK PLACES NOT SHOWN ABOVE - SEE ATTACHED EXTENSION OF INFORMATION PAGE

Item 2. POLICY PERIOD
12:01 A.M. standard time at the insured's mailing address FROM TO

Item 3. A. WORKERS COMPENSATION INSURANCE: Part One of the policy applies to the Workers Compensation Law of the states listed here: Refer To Extension of Information Page "Covered States"

B. EMPLOYERS LIABILITY INSURANCE: Part Two of the policy applies to work in each statelisted in Item 3A. The limits of our liability under Part Two are:

Bodily Injury by Accident	$	each accident
Bodily Injury by Disease	$	policy limit
Bodily Injury by Disease	$	each employee

C. OTHER STATES INSURANCE: Part Three of the policy applies to the states, if any, listed here: All States, Except states designated in Item 3.A and

D. Endorsements (Form No.) Refer To Extension of Information Page "List of Endorsements & Schedules"

Item 4. The Premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Refer to Extension of Information Page

Minimum Premium:		Total Estimated Premium	$
Minimum Premium State:		Total State Surcharges	$
Expense Constant:		Total Estimated Charge	$
Premium Adjustment Period:		Deposit Amount	$

Authorized Representative and Date Signed

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of Policy Number

Policy Period **to**

FEIN

Effective Date

Name & Address of the Producer

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGE

ITEM 1.

NAMED INSURED

It is agreed that Item 1 of the Workers Compensation and Employers Liability Policy Information Page includes the following Named Insureds:

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period **to**

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGES
ITEM 3.A.
COVERED STATES

It is agreed that Item 3.A. of the Workers Compensation and Employers Liability Policy Information Page includes the following states:

State	Risk I.D.	State I.D. No.

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period **to**

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

Producer Number

EXTENSION OF INFORMATION PAGES

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES

It is agreed that Item 3.D. of the Workers Compensation and Employers Liability Policy Information Page includes the following endorsements and schedules:

All Other Terms and Conditions Remain Unchanged

_____
Authorized Representative

Issue Date

Name & Mailing Address of the Insured

Attached to and Forming Part of
Policy Number
Policy Period **to**

FEIN
Name & Address of the Producer

Effective Date

Name of Company

Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4

SCHEDULE NUMBER:

Classifications of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date

SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CHUB-125640433*	*State:*	*Arkansas*
First Filing Company:	*Chubb Indemnity Insurance Company, ...*	*State Tracking Number:*	*#? $50*
Company Tracking Number:	*08-C-4-F*		
TOI:	*16.0 Workers Compensation*	*Sub-TOI:*	*16.0000 WC Sub-TOI Combinations*
Product Name:	*Workers Compensation*		
Project Name/Number:	*Great Northern Redomestication/08-C-4-RR*		

Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-Property & Casualty

Review Status: Approved 05/15/2008

Comments:

Attachments:

AR PCtrans03-01-07 .pdf

NAIC FFS NM.pdf

Satisfied -Name: IN Re-domestication Letter

Review Status: Approved 05/15/2008

Comments:

Attachment:

IN letter.pdf

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only

2. Insurance Department Use only	
a. Date the filing is received:	
b. Analyst:	
c. Disposition:	
d. Date of disposition of the filing:	
e. Effective date of filing:	
New Business	
Renewal Business	
f. State Filing #:	
g. SERFF Filing #:	
h. Subject Codes	

3.	Group Name	Group NAIC #
	Chubb Group of Insurance Companies	038

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	Federal Insurance Company	Indiana	20281	13-1963496	
	Vigilant Insurance Company	New York	20397	13-1963495	
	Great Northern Insurance Company	Indiana	20303	41 0729473	
	Pacific Indemnity Company	New York	20346	95-1078160	
	Chubb Indemnity Company	Wisconsin	12777	22-3291862	

5.	Company Tracking Number	08-C-4-F

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Jane Gutman, 202 Hall's Mill Road, P.O. Box 1650, Whitehouse, NJ 08889-1650	Manager, CCI State Filings Department	(908) 572-4422	(908)572-4820	jgutman@chubb.com

7.	Signature of authorized filer	*Jane Gutman*
8.	Please print name of authorized filer	Jane Gutman

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	16 Workers Compensation
10.	**Sub-Type of Insurance (Sub-TOI)**	
11.	**State Specific Product code(s)(if applicable)[See State Specific Requirements]**	
12.	**Company Program Title** (Marketing title)	Commercial Auto
13.	**Filing Type**	[ ] Rate/Loss Cost [ ] Rules [ ] Rates/Rules [**X**] Forms [ ] Combination Rates/Rules/Forms [ ] Withdrawal [ ] Other (give description)
14.	**Effective Date(s) Requested**	New: Renewal:
15.	**Reference Filing?**	[ ] Yes [X] No
16.	**Reference Organization** (if applicable)	
17.	**Reference Organization # & Title**	
18.	**Company's Date of Filing**	5-14-08
19.	**Status of filing in domicile**	[ ] Not Filed [X] Pending [ ] Authorized [ ] Disapproved

Property & Casualty Transmittal Document—

20.	**This filing transmittal is part of Company Tracking #**	08-C-4-F

21.	**Filing Description** [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

Informational Filing

Dear Sir or Madam:

Enclosed for your information are the following:

Information Page and Extension of Information Pages, Form WC 00 00 01A (Rev. 5-88)

Effective November 30, 2007, Great Northern Insurance Company was re-domesticated from Minnesota to Indiana. We have enclosed a copy of the letter approving the re-domestication to Indiana as submitted to us by the Commissioner of Indiana.

We are enclosing the Information Page and Extension of Information Pages for all writing companies removing the incorporated state and the entry under 3C, Other States Insurance. This filing is classified as informational as the fields in question are variable fields that are now being submitted unfilled so as to eliminate this as an issue going forward should another company be re-domesticated or another state cease being monopolistic (for field 3C). This is an informational only filing as the forms are identical in content/text but differ in appearance; the information does not affect an insureds policy nor does it impact the quality of coverage.

Your acknowledgment will be appreciated.

22.	**Filing Fees** (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: 370661, 370662, 370663, 370664, 370665
Amount: 50 each for a total of $250

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

Effective January 1, 2006

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)

(Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	08-C-4-F
2.	**This filing corresponds to rate/rule filing number** (Company tracking number of rate/rule filing, if applicable)	

3.	**Form Name /Description/Synopsis**	**Form # Include edition date**	**Replacement or Withdrawn?**	**If replacement, give form # it replaces**	**Previous state filing number, if required by state**
01	Information Page and Extension of Information Pages	WC 00 00 01A (Rev. 5-88)	☑ Replacement ☐ Withdrawn ☐ Neither	WC 00 00 01A (Rev. 5-88)	
02	Information Page and Extension of Information Pages	WC 00 00 01A (Rev. 5-88)	☑ Replacement ☐ Withdrawn ☐ Neither	WC 00 00 01A (Rev. 5-88)	
03	Information Page and Extension of Information Pages	WC 00 00 01A (Rev. 5-88)	☑ Replacement ☐ Withdrawn ☐ Neither	WC 00 00 01A (Rev. 5-88)	
04	Information Page and Extension of Information Pages	WC 00 00 01A (Rev. 5-88)	☑ Replacement ☐ Withdrawn ☐ Neither	WC 00 00 01A (Rev. 5-88)	
05	Information Page and Extension of Information Pages	WC 00 00 01A (Rev. 5-88)	☑ Replacement ☐ Withdrawn ☐ Neither	WC 00 00 01A (Rev. 5-88)	
06			☐ Replacement ☐ Withdrawn ☐ Neither		
07			☐ Replacement ☐ Withdrawn ☐ Neither		
08			☐ Replacement ☐ Withdrawn ☐ Neither		
09			☐ Replacement ☐ Withdrawn ☐ Neither		
10			☐ Replacement ☐ Withdrawn ☐ Neither		
11			☐ Replacement ☐ Withdrawn ☐ Neither		
12			☐ Replacement ☐ Withdrawn ☐ Neither		
13			☐ Replacement ☐ Withdrawn ☐ Neither		
14			☐ Replacement ☐ Withdrawn ☐ Neither		
15			☐ Replacement ☐ Withdrawn ☐ Neither		
16			☐ Replacement ☐ Withdrawn ☐ Neither		

F 778 (Ed. 1/06) **UNIFORM**

STATE OF INDIANA

MITCHELL E. DANIELS, JR., Governor

IDOI

INDIANA DEPARTMENT OF INSURANCE
311 W. WASHINGTON STREET, SUITE 300
INDIANAPOLIS, INDIANA 46204-2787
TELEPHONE: (317) 232-2385
FAX: (317) 232-5251

JAMES ATTERHOLT, Commissioner

November 30, 2007

Thomas Motamed
President
Great Northern Insurance Company
15 Mountain View Road
Warren, NJ 07061

Dear Mr. Motamed:

I am pleased to inform you that I have approved your company's application for redomestication to the State of Indiana. Enclosed is your Indiana Certificate of Authority. This Certificate is renewable annually; however, the Indiana Department of Insurance will not issue a duplicate Certificate upon renewal.

With this Certificate, your company now has all rights, privileges, and obligations of an Indiana domestic insurance company. Within thirty days of receipt of your company's Certificate, you must file Form D(s) for all affiliated agreements in accordance with Indiana Code 27-1-23-4 and Rule 15.1 (760: 1-15.1-7).

I am confident that your company accepts the responsibility of providing high quality insurance coverage to policyholders. I know that you will work diligently toward our common goal of serving the policy-buying public through qualified, well trained employees and agents.

I invite your company to avail itself of any assistance for services provided by the Department. If you have any questions, comments, or concerns, please do not hesitate to contact us. Congratulations, and welcome to Indiana!

Sincerely,

James Atterholt

James Atterholt
Commissioner

Enclosures: